STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G447	A. BUILDING 00 B. WING	11/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA CORPORATION OF INDIANA	4114 KNOLLTON RD INDIANAPOLIS, IN 46228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for a fundamental annual recertification and state licensure survey. Dates of Survey: 11/5/14, 11/6/14, 11/10/14 and 11/12/14 Facility Number: 000961 Provider Number: 15G447 AIMS Number: 100244750 Surveyor: Keith Briner, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/24/14 by Ruth Shackelford, QIDP.	W000000		
W000125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to ensure clients #1, #2, #3 and #4's individual rights were not violated by the facility's practice of restricting access to soda without due	W000125	**CORRECTION:** *The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility,*	12/12/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	process or assessed need. Findings include: Observations were conducted at the group home on 11/5/14 at 5:00 PM through 6:05 PM. At 5:30 PM, client #2 walked into the group home's kitchen area where staff #1 was standing. Client #2 stated, "Pop. Pop." Staff #1 replied, "Not tonight." Client #2 then returned to the living room area. At 5:45 PM, client #8 returned to the group home from an outing with her family. Client #8 had a fast food cup with soda. Client #2 approached client #8, stretched her hands out toward the cup and stated, "Pop, pop." Client #2 was redirected and client #8 left the area. At 6:04 PM, client #2 stood in the hallway between the kitchen area and the dining area pointing with her hands to the top of the kitchen cabinet. On the top of the kitchen cabinet was a fast food cup of soda. Client #2 pointed toward the cup and stated, "Pop, Pop." Staff #1 was interviewed on 11/5/14 at 5:35 PM. Staff #1 stated, "They only get pop on Friday. That's when we go out to eat." CS #2 (Clinical Supervisor) was interviewed on 11/6/14 at 2:15 PM. CS #2 indicated clients #1, #2, #3 and #4		*and as citizens of the United States, including the right to file complaints, and the right to due process.*Specifically for Clients #1, #2, #3 and #4, through assessment, the interdisciplinary team has determined that only one individual (Client #2) needs to have limited access to soft drinks for documented health reasons. The modification of this right will be incorporated into Client #2's support plan based on physician recommendations and after written informed consent from client #2's guardian and Human Rights Committee approval has been obtained. Through assessment, the team determined that this deficient practice affected 4 additional clients: #5, #6, #7 and #8. Access to soft drinks will not be limited for these individuals. **PERVENTION:** Staff will be retrained regarding the need to refrain from bringing personal items into the facility that could present a distraction to skill acquisition and the active treatment process. These items will include but not be limited to large containers of snacks and soft drinks. The QIDP has been retrained regarding the need to assure restrictive measures are	

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	could have diet soda if they choose. 1. Client #1's record was reviewed on 11/6/14 at 1:00 PM. Client #1's MIRF (Modification of Individual's Rights Form) dated 12/7/13 indicated client #1 should be restricted from concentrated sweets. Client #1's MIRF dated 12/7/13 did not indicate client #1 should be restricted from diet soda/sugar free soda options. Client #1's record did not indicate documentation of client #1 being assessed as needing to be restricted from diet/sugar free soda options. 2. Client #2's record was reviewed on 11/6/14 at 9:36 AM. Client #2's MIRF dated 8/14/14 indicated client #2 should be restricted from concentrated sweets. Client #2's MIRF dated 8/14/14 did not indicate client #2 should be restricted from diet soda/sugar free soda options. Client #2's record did not indicate documentation of client #2 being assessed as needing to be restricted from diet/sugar free soda options. 3. Client #3's record was reviewed on 11/6/14 at 12:00 PM. Client #3's MIRF dated 11/14/13 indicated client #3 should be restricted from concentrated sweets. Client #3's MIRF dated 11/14/13 did not indicate client #3 should be restricted from diet soda/sugar free soda options.		implemented only when an assessed need has been identified and informed consent has been obtained. The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring, including but not limited to assessing client's need for restrictive programs and their ability to give informed consent. Members of the Operations Team will review facility support documents no less than monthly to assure that accurate informed consent assessments are in place and that prior written informed consent is obtained for all restrictive programs. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Operations Team	

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	Client #3's record did not indicate documentation of client #3 being assessed as needing to be restricted from diet/sugar free soda options. 4. Client #4's record was reviewed on 11/6/14 at 11:13 AM. Client #4's MIRF dated 11/21/13 indicated client #4 should be restricted from concentrated sweets. Client #4's MIRF dated 11/21/13 did not indicate client #4 should be restricted from diet soda/sugar free soda options. Client #4's record did not indicate documentation of client #4 being assessed as needing to be restricted from diet/sugar free soda options. Client #4 was interviewed on 11/10/14 at 12:45 PM. When asked if she was able to drink soda in her group home, client #4 stated, "We do sometimes. We had some this weekend. We don't get it too often." 9-3-2(a)			
W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 4 sampled clients (#3), the facility failed to implement its policy and procedures to prevent neglect of client #3	W000149	**CORRECTION:** *The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.* Specifically:	12/12/2014

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	regarding her ingestion of psychotropic medication not prescribed to her, conduct an investigation regarding client #3's ingestion of psychotropic medication not prescribed to her and to develop and implement corrective actions to prevent client #3 from additional ingestion of psychotropic medication not prescribed to her. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/5/14 at 2:18 PM. The review indicated the following: -BDDS report dated 8/4/14 indicated, "[Client #3] opened the medication room door as staff was preparing medication for another individual and grabbed the medication cup on the counter and took a 2 milligram Risperidone tablet. This medication was not prescribed for [client #3]. The nurse and administrative staff were notified of this incident. The nurse spoke to the on call pharmacist and he said to not give [client #3] her Seroquel tablet but she could have all her other medication. [Client #3] will receive a late dosage of the Seroquel. The only side effect he anticipated was possibly drowsiness. Staff continued to monitor		The Residential Manager and members of the administrative investigation team have been retrained on components of a thorough investigation, specifically that all potential witnesses must be interviewed. Additionally, the manager and investigative team have been retrained regarding the need to review all relevant documents including but not limited to progress notes and behavior tracking as part of the investigation process. Additionally, the Governing Body has revised the criteria for incidents requiring investigation to include events where staff could potentially have failed to implement safety protocols including but not limited to Comprehensive High Risk Plans. All supervisory staff will receive training toward implementation of the revised policy. The facility will retrain all staff on the agency's medication administration procedures including the need to keep the medication room locked at all times and to assure once medications are prepared for administration, they are kept out of reach of clients who may force their way into the medication room prior to being prompted to take their medication. **PREVENTION:** Investigations of allegations of abuse, neglect and mistreatment will undergo a formal peer review process to	

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	[client #3] the remainder of the shift and throughout the night." -The review did not indicate documentation of an investigation to describe and explain the factors contributing to client #3's ingestion of her peer's Risperidone 2 milligram tablet. The review did not indicate documentation of a finding of fact and determination as to whether client #3's rights were violated, concerns and recommendations and methods to prevent future incidents. Client #3's record was reviewed on 11/6/14 at 12:00 PM. Client #3's physician's order form dated 9/19/14 did not indicate client #3 should receive Risperidone 2 milligrams. CS (Clinical Supervisor) #1 was interviewed on 11/5/14 at 2:15 PM. CS #1 indicated the facility's abuse and neglect policy should be implemented. CS #1 indicated allegations of abuse, neglect, mistreatment and injuries of unknown origin should be investigated. CS #1 indicated corrective action to prevent reoccurrence of abuse, neglect, mistreatment or injuries of unknown origin should be developed from the IDT (Interdisciplinary Team) or from the investigation peer review process.		ensure the investigations are thorough. The Peer Review Team will be composed of administrative level staff including the Executive Director, Program Manager, Clinical Supervisors and a representative from the Human Resources Department. Additionally, the Residential Manager will turn in copies of completed internal facility investigations to the Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will follow-up with the Residential Manager as needed but no less than weekly to review incident documentation and completed investigations to assure they have been completed thoroughly. **ADDENDUM, 12/21/14: The Clinical Supervisor will provide the Operations Team and front line Supervisors with daily updates of incidents requiring investigation. These updates will be reviewed by both the Program Manager and Executive Director. The Program Manager will provide a weekly report to the Executive Director regarding the status of open investigations at the facility for the purpose of holding the QIDP and other team members accountable for completing thorough investigations within established timelines.** Completed abuse, neglect and	

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	The facility's policy and procedures were reviewed on 11/10/14 at 3:45 PM. The facility's Abuse, Neglect, Exploitation and Mistreatment policy dated 2/26/11 indicated, "Program intervention neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm." The 2/26/11 policy indicated, "Medical neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide necessary medical attention, proper nutritional support or administering medications as prescribed." The facility's Investigations policy dated 9/14/07 indicated, "In order to ensure the health, safety and welfare of the people we support, events or collections of circumstances that are outside of what is normally expected, cannot by (sic) explained and understood by the existence of the event and result in or have the potential to result in injury or abuse, neglect or exploitation to the consumer must be investigated." The 9/14/07 policy indicated investigations should include "Finding of fact and determination as to whether or not the allegations are substantiated, unsubstantiated or inconclusive. Concerns and recommendations.... Methods to prevent future incidents."		mistreatment investigations will be reviewed as part of a formal quarterly audit process. When deficiencies are noted, the Executive Director will amend the agency's Quality Improvement Plan to correct and prevent future occurrences. The QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to falls and discovered injuries to review current supports and to make adjustments and revisions as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes to the Program Manager and Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require interdisciplinary team action. The Residential Manager will be expected to observe no less than one morning and one evening active treatment session per week and the Team Leader will be required to observe and participate in active treatment sessions on varied shifts no less than five times per week. During Active Treatment observations, supervisors will assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff follow medication administration procedures and implement	

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	9-3-2(a)		behavior supports and safety protocols. Additionally, members of the Operations Team and the QIDP will conduct active treatment observations on a weekly basis for the next 30 days, providing hands-on coaching and training as needed. After two months, The Operations team and QIDP will observe active treatment sessions no less than every two weeks for an additional 60 days. After 90 days, the Operations Team will review incident data and observational assessments to determine the need for ongoing oversight, with the goal of scaling back the administrative presence in the home to no less than monthly. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	
W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 3 allegations of abuse, neglect, mistreatment and injuries of unknown origin reviewed, the facility failed to conduct an investigation regarding client #3's ingestion of psychotropic medication not prescribed to her. Findings include:	W000154	**CORRECTION:** *The facility must have evidence that all alleged violations are thoroughly investigated.* Specifically, the Residential Manager and members of the administrative investigation team have been retrained on components of a thorough investigation, specifically that all potential witnesses must be interviewed. Additionally, the manager and	12/12/2014

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	The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/5/14 at 2:18 PM. The review indicated the following: -BDDS report dated 8/4/14 indicated, "[Client #3] opened the medication room door as staff was preparing medication for another individual and grabbed the medication cup on the counter and took a 2 milligram Risperidone tablet. This medication was not prescribed for [client #3]. The nurse and administrative staff were notified of this incident. The nurse spoke to the on call pharmacist and he said to not give [client #3] her Seroquel tablet but she could have all her other medication. [Client #3] will receive a late dosage of the Seroquel. The only side effect he anticipated was possibly drowsiness. Staff continued to monitor [client #3] the remainder of the shift and throughout the night." -The review did not indicate documentation of an investigation to describe and explain the factors contributing to client #3's ingestion of her peer's Risperidone 2 milligram tablet. The review did not indicate documentation of a finding of fact and determination as to whether client #3's rights were violated.		investigative team have been retrained regarding the need to review all relevant documents including but not limited to progress notes and behavior tracking as part of the investigation process. Additionally, the Governing Body has revised the criteria for incidents requiring investigation to include events where staff could potentially have failed to implement safety protocols including but not limited to Comprehensive High Risk Plans. All supervisory staff will receive training toward implementation of the revised policy.**PREVENTION:** Investigations of allegations of abuse, neglect and mistreatment will undergo a formal peer review process to ensure the investigations are thorough. The Peer Review Team will be composed of administrative level staff including the Executive Director, Program Manager, Clinical Supervisors and a representative from the Human Resources Department. Additionally, the Residential Manager will turn in copies of completed internal facility investigations to the Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will follow-up with the Residential Manager as needed but no less than weekly to review incident documentation and completed investigations to assure they have	

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	Client #3's record was reviewed on 11/6/14 at 12:00 PM. Client #3's physician's order form dated 9/19/14 did not indicate client #3 should receive Risperidone 2 milligrams. CS (Clinical Supervisor) #1 was interviewed on 11/5/14 at 2:15 PM. CS #1 indicated allegations of abuse, neglect, mistreatment and injuries of unknown origin should be investigated. 9-3-2(a)		been completed thoroughly. **ADDENDUM, 12/21/14: The Clinical Supervisor will provide the Operations Team and front line Supervisors with daily updates of incidents requiring investigation. These updates will be reviewed by both the Program Manager and Executive Director. The Program Manager will provide a weekly report to the Executive Director regarding the status of open investigations at the facility for the purpose of holding the QIDP and other team members accountable for completing thorough investigations within established timelines.** Completed abuse, neglect and mistreatment investigations will be reviewed as part of a formal quarterly audit process. When deficiencies are noted, the Executive Director will amend the agency's Quality Improvement Plan to correct and prevent future occurrences. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	
W000157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 3 allegations of abuse, neglect, mistreatment and injuries of unknown	W000157	**CORRECTION:** *If the alleged violation is verified, appropriate corrective action must be taken.* Specifically, the facility will retrain	12/12/2014

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	origin reviewed, the facility failed to develop and implement corrective actions to prevent client #3 from additional ingestion of psychotropic medication not prescribed to her. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/5/14 at 2:18 PM. The review indicated the following: -BDDS report dated 8/4/14 indicated, "[Client #3] opened the medication room door as staff was preparing medication for another individual and grabbed the medication cup on the counter and took a 2 milligram Risperidone tablet. This medication was not prescribed for [client #3]. The nurse and administrative staff were notified of this incident. The nurse spoke to the on call pharmacist and he said to not give [client #3] her Seroquel tablet but she could have all her other medication. [Client #3] will receive a late dosage of the Seroquel. The only side effect he anticipated was possibly drowsiness. Staff continued to monitor [client #3] the remainder of the shift and throughout the night." -The review did not indicate		all staff on the agency's medication administration procedures including the need to keep the medication room locked at all times and to assure once medications are prepared for administration, they are kept out of reach of clients who may force their way into the medication room prior to being prompted to take their medication. **PREVENTION:** The QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to falls and discovered injuries to review current supports and to make adjustments and revisions as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes to the Program Manager and Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require interdisciplinary team action. The Residential Manager will be expected to observe no less than one morning and one evening active treatment session per week and the Team Leader will be required to observe and participate in active treatment sessions on varied shifts no less than five times per week. During Active Treatment observations, supervisors will assess direct support staff interaction with clients and to provide hands on	

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	documentation of concerns and recommendations and methods to prevent future incidents. Client #3's record was reviewed on 11/6/14 at 12:00 PM. Client #3's physician's order form dated 9/19/14 did not indicate client #3 should receive Risperidone 2 milligrams. Client #3's record did not indicate documentation of IDT (Interdisciplinary Team) review of the 8/4/14 incident to make recommendations to prevent recurrence. CS (Clinical Supervisor) #1 was interviewed on 11/5/14 at 2:15 PM. CS #1 indicated corrective action to prevent reoccurrence of abuse, neglect, mistreatment or injuries of unknown origin should be developed from the IDT or from the investigation peer review process. 9-3-2(a)		coaching and training including but not limited to assuring staff follow medication administration procedures and implement behavior supports and safety protocols. Additionally, members of the Operations Team and the QIDP will conduct active treatment observations on a weekly basis for the next 30 days, providing hands-on coaching and training as needed. **ADDENDUM 12/21/14: After one month, The Operations team and QIDP will observe active treatment sessions no less than every two weeks on an ongoing basis. RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Health Services Team, Operations Team	
W000159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the QIDP (Qualified	W000159	**CORRECTION:** *Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental*	12/12/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Intellectual Disabilities Professional) failed to integrate, coordinate and monitor clients #1, #2, #3 and #4's active treatment programs for progression/regression of skills, ensure staff working with client #2 were trained regarding client #2's dietary orders, ensure client #2's guardian participated in the development of her ISP (Individual Support Plan), ensure the facility provided aggressive implementation of client #3's active treatment program, ensure the facility's HRC (Human Rights Committee) reviewed and approved client #1's use of psychotropic medication for pre-sedation for dental procedures, ensure the facility's HRC obtained the written informed consent of clients #1 and #2's guardians regarding the use of psychotropic medication for behavior management and ensure the HRC reviewed the facility's practice of restricting clients #1, #2, #3 and #4 from soda. Findings include: 1. Client #1's record was reviewed on 11/6/14 at 1:00 PM. Client #1's QIDP monthly review form dated 7/1/14 indicated the QIDP had reviewed client #1's formal ISP objectives for progression/regression of skills. Client #1's record did not indicate		*retardation professional.* Specifically: The QIDP will be retrained regarding the need to monitor clients' active treatment programs for progression and regression. A review of documentation indicated this deficient practice affected all clients residing in the facility. The team has obtained clarification regarding the appropriate modified texture of Client #2's diet and will train all staff toward proper implementation of the prescribed diet. A review of dietary recommendations indicated this deficient practice affected one additional individual –Client # 5. Staff will also be trained toward proper implementation of this prescribed diet. The QIDP will be retrained regarding the need to bring all elements of the interdisciplinary team including guardian and family members, to assist with the development of individual support plans. A review of support documents indicated this deficient practice did not affect any additional clients. The QIDP will review Client #2's plan with the guardian, obtain approval for current supports and make modifications per guardian input if applicable. The QIDP will facilitate retraining of all direct support staff regarding the need to provide consistent, aggressive and continuous active treatment for Client #3 including but not limited to offering options for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G447	A. BUILDING 00 B. WING	11/12/2014

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	documentation of QIDP review of client #1's progression/regression of ISP training objectives/skills since 7/1/14. 2. Client #2's record was reviewed on 11/6/14 at 9:36 AM. Client #2's QIDP monthly review form dated 7/1/14 indicated the QIDP had reviewed client #2's formal ISP objectives for progression/regression of skills. Client #2's record did not indicate documentation of QIDP review of client #2's progression/regression of ISP training objectives/skills since 7/1/14. 3. Client #3's record was reviewed on 11/6/14 at 12:00 PM. Client #3's QIDP monthly review form dated 7/1/14 indicated the QIDP had reviewed client #3's formal ISP objectives for progression/regression of skills. Client #3's record did not indicate documentation of QIDP review of client #3's progression/regression of ISP training objectives/skills since 7/1/14. 4. Client #4's record was reviewed on 11/6/14 at 11:13 AM. Client #4's QIDP monthly review form dated 7/1/14 indicated the QIDP had reviewed client #4's formal ISP objectives for progression/regression of skills. Client #4's record did not indicate documentation of QIDP review of client		appropriate activities at frequent intervals and training toward prioritized learning objectives per the implementation schedule. Administrative Team observation of active treatment determined that this deficient practice did not affect additional clients. The facility has located documentation of approval from the Human Rights Committee for Client #1's use of psychotropic medication for pre-sedation for dental procedures. For Clients #1, #2, #3 and #4, through assessment, the interdisciplinary team has determined that only one individual (Client #2) needs to have limited access to soft drinks for documented health reasons. The modification of this right will be incorporated into Client #2's support plan based on physician recommendations and after written informed consent from client #2's guardian and Human Rights Committee approval has been obtained. Through assessment, the team determined that this deficient practice affected 4 additional clients: #5, #6, #7 and #9. Access to soft drinks will not be limited for these individuals. **PERVENTION:** The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring. The Clinical Supervisor and Program Manager will review Individual Support Plan	

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	#4's progression/regression of ISP training objectives/skills since 7/1/14. CS #2 (Clinical Supervisor) was interviewed on 11/6/14 at 2:15 PM. CS #2 indicated there was not additional documentation of QIDP review of clients #1, #2, #3 or #4's ISP training objectives. CS #2 indicated the QIDP should review clients #1, #2, #3 and #4's training objectives on a monthly basis and make revisions to goals based on progression/regression of skills. 5. The QIDP failed to ensure staff working with client #2 were trained regarding client #2's dietary orders. Please see W189. 6. The QIDP failed to ensure client #2's guardian participated in the development of her ISP. Please see W209. 7. The QIDP failed to ensure the facility provided aggressive implementation of client #3's active treatment program. Please see W249. 8. The QIDP failed to ensure the facility's HRC reviewed and approved client #1's use of psychotropic medication for pre-sedation for dental procedures. Please see W262.		Summaries no less that monthly to assure the QIDP monitors clients for progression and regression and modifies plans accordingly. The Residential Manager will be expected to observe no less than one morning and one evening active treatment session per week and the Team Leader will be required to observe and participate in active treatment sessions on varied shifts no less than five times per week. During Active Treatment observations, supervisors will assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff provide continuous active treatment to all clients, follow medication administration procedures, implement behavior supports and safety protocols and implement prescribed diets. Additionally, members of the Operations Team and the QIDP will conduct active treatment observations on a weekly basis for the next 30 days, providing hands-on coaching and training as needed. **ADDENDUM, 12/21/14: After one month, The Operations Team and QIDP will observe active treatment sessions and review documentation no less than every two weeks. The Operations Team will maintain no less than a twice monthly presence in the home on an ongoing basis, to assure that**	

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	15G447	A. BUILDING 00 B. WING	11/12/2014

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	8. The QIDP failed to ensure the facility's HRC obtained the written informed consent of clients #1 and #2's guardians regarding the use of psychotropic medication for behavior management. Please see W263. 9. The QIDP failed to ensure the HRC reviewed the facility's practice of restricting clients #1, #2, #3 and #4 from soda. Please see W264. 9-3-3(a)		**the QIDP integrates, coordinates and monitors all aspects of the active treatment process.**The QIDP will turn in documentation of family/guardian communication to the Program Manager monthly. The Program Manager will in turn follow-up to assure that family members and guardians are invited and encouraged to participate in the ISP development process. The QIDP will be retrained regarding the need to assure that the Human Rights Committee engages in a dialog to reach decisions regarding restrictive programs for all clients. The QIDP, facility nurse and Human Rights Committee liaison will each maintain copies of Human rights Committee approval forms to assure the ability to reproduce copies of HRC records for surveyors upon request. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to, due process and prior written informed consent. Administrative staff will conduct visits to the facility on a bi-weekly basis for the next 30 days. **ADDENDUM, 12/21/14: After one month, The Operations Team and QIDP will observe active treatment sessions and review documentation no less than every two weeks. The Operations Team will maintain no less than a twice monthly**	

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	15G447	A. BUILDING 00 B. WING	11/12/2014

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W000189	483.430(e)(1)		**presence in the home on an ongoing basis, to assure that the QIDP integrates, coordinates and monitors all aspects of the active treatment process.** The Program Manager will incorporate monitoring of annual HRC approvals of restrictive programs into the current tracking process. The QIDP will be retrained regarding the need to obtain prior written informed consent from guardians, advocates and healthcare representatives for all restrictive programs prior to implementation. Retraining will focus on assuring that the QIDP has a clear understanding of what specifically constitutes a restrictive program and proper preparation for presenting program modifications guardians and other legal representatives. Prior to granting approval to restrictive programs, the Human Rights Committee will obtain confirmation that the facility has received prior written informed consent from guardians or other legal representatives. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to due process and prior written informed consent. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	

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	STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation, record review and interview for 1 of 4 sampled clients (#2), the facility failed to ensure staff working with client #2 were trained regarding client #2's dietary orders. Findings include: RM (Resident Manager) #1 was interviewed on 11/5/14 at 5:53 PM. When asked which clients had specialized diet orders, i.e. mechanical soft, pureed, thick liquids, RM #1 stated, "[Client #6] is mechanical soft. Everyone else is regular. [Client #6] is the only one." Observations were conducted at the group home on 11/5/14 from 5:00 PM through 6:15 PM. At 6:04 PM, client #2 participated in the group home's family style evening meal. Client #2 ate pizza and salad. Client #2's food was not chopped or mechanical soft. Client #2's record was reviewed on 11/6/14 at 9:36 AM. Client #2's Record of Visit (ROV) form dated 6/21/12 indicated client #2 should have a	W000189	**CORRECTION:** *The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.* Specifically, the team has obtained clarification regarding the appropriate modified texture of Client #2's diet and will train all staff toward proper implementation of the prescribed diet. A review of dietary recommendations indicated this deficient practice affected one additional individual –Client # 5. Staff will also be trained toward proper implementation of this prescribed diet. **PREVENTION:** The Residential Manager will be expected to observe no less than one morning and one evening active treatment session per week and the Team Leader will be required to observe and participate in active treatment sessions on varied shifts no less than five times per week. During Active Treatment observations, supervisors will assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff implement prescribed diets. Additionally, members of the	12/12/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	mechanical soft diet to prevent choking. Client #2's Comprehensive High Risk Health Plan (CHRHP) dated 7/7/14 indicated, "Follow mechanical soft with thin liquids 5 milliliter control flow cup guidelines at all times." CS (Clinical Supervisor) #2 was interviewed on 11/6/14 at 2:15 PM. CS #2 indicated RM #1 should know client #2's dietary orders and ensure staff working with client #2 were trained to implement the orders. 9-3-3(a)		Operations Team and the QIDP will conduct active treatment observations on a weekly basis for the next 30 days, providing hands-on coaching and training as needed. **ADDENDUM, 12/21/14: After one month, The Operations Team and QIDP will observe active treatment sessions and review documentation no less than every two weeks. The Operations Team will maintain no less than a twice monthly presence in the home on an ongoing basis, to assure that the QIDP integrates, coordinates and monitors all aspects of the active treatment process. RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	
W000209	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. Based on record review and interview for 1 of 4 sampled clients (#2), the facility failed to ensure client #2's guardian participated in the development of her ISP (Individual Support Plan). Findings include: Client #2's record was reviewed on	W000209	**CORRECTION:** *Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate.* Specifically for Client #2 the QIDP and Residential Manager will be	12/12/2014

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	11/6/14 at 9:36 AM. Client #2's ISP dated 8/14/14 indicated client #2 had a legal guardian. Client #2's ISP did not indicate documentation of client #2's guardian's signature/participation in completing client #2's ISP. Client #2's PCP (Person Centered Planning) form dated 8/14/14 did not indicate documentation of client #2's guardian's signature/participation in the planning of client #2's ISP. CS (Clinical Supervisor) #2 was interviewed on 11/6/14 at 2:15 PM. CS #2 indicated there was not additional documentation of client #2's guardian's participation in the development and planning of client #2's ISP. 9-3-4(a)		retrained regarding the need to bring all elements of the interdisciplinary team including guardian and family members, to assist with the development of individual support plans. A review of support documents indicated this deficient practice did not affect any additional clients. The QIDP will review Client #2's plan with the guardian, obtain approval for current supports and make modifications per guardian input if applicable. A review of facility support documents indicated this deficient practice did not affect additional clients. **PERVENTION:** The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring. The QIDP will turn in documentation of family/guardian communication to the Program Manager monthly. The Program Manager will in turn follow-up to assure that family members and guardians are invited and encouraged to participate in the ISP development process. **RESPONSIBLE PARTIES:**	

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			QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	
W000249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview for 1 of 4 sampled clients (#3), the facility failed to provide aggressive implementation of client #3's active treatment program. Findings include: Observations were conducted at the group home on 11/5/14 from 5:00 PM through 6:00 PM. Client #3 was observed throughout the observation period. Client #3 paced from her bedroom, to the kitchen, to the living room area and returned to the her bedroom from 5:00 PM through 5:45 PM. Client #3 repeated her pacing routine and did not engage in meal preparation, socializing with her peers or participate in the group home's game activity. Client #3 was not coached or prompted to join or participate in the home's activity. At 5:45 PM, client #3 joined her peers in the dining area for the	W000249	**CORRECTION:** *As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.* Specifically, all direct support staff will be retrained regarding the need to provide consistent, aggressive and continuous active treatment for Client #3 including but not limited to offering options for appropriate activities at frequent intervals and training toward prioritized learning objectives per the implementation schedule. Administrative Team observation of active treatment determined that this deficient practice did not affect additional clients. **PREVENTION:** The Residential Manager will be expected to	12/12/2014

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	15G447	A. BUILDING 00 B. WING	11/12/2014

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	home's family style evening meal. Observations were conducted at the group home on 11/6/14 from 6:15 AM through 7:30 AM. Client #3 paced from her bedroom, to the kitchen, to the living room area and returned to the her bedroom from 6:15 AM through 6:40 AM. At 6:45 AM, client #3 joined her peers for the home's family style breakfast. At 7:05 AM, client #3 finished eating her breakfast and resumed pacing from her bedroom, to the kitchen, to the living room area and returned to the her bedroom. Client #3's record was reviewed on 11/6/14 at 12:00 PM. Client #3's ISP (Individual Support Plan) dated 11/14/13 indicated client #3 had formal training objectives to communicate her wants, needs and emotions, participate in a physical activity, bathe her body, brush her teeth, identify a penny, identify her medication, participate in an activity, assist in cooking a meal and set her fork/spoon down between bites of food. CS (Clinical Supervisor) #2 was interviewed on 11/6/14 at 2:15 PM. CS #2 indicated active treatment should occur at every available opportunity. 9-3-4(a)		observe no less than one morning and one evening active treatment session per week and the Team Leader will be required to observe and participate in active treatment sessions on varied shifts no less than five times per week. The QIDP will also maintain an ongoing presence at the facility. During Active Treatment observations, supervisors will assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff implement learning objectives and provide frequent choices of activities. Additionally, members of the Operations Team and the QIDP will conduct active treatment observations on a weekly basis for the next 30 days, providing hands-on coaching and training as needed to assure staff implement learning objectives and implement behavior supports and risk plans as written. Additionally, The Operations Team and QIDP will observe active treatment sessions weekly for the next 30 days. **ADDENDUM, 12/21/14: After one month, The Operations Team and QIDP will observe active treatment sessions and review documentation no less than every two weeks. The Operations Team will maintain no less than a twice monthly presence in the home on an ongoing basis, to assure that**	

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	15G447	A. BUILDING 00 B. WING	11/12/2014

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			the QIDP integrates, coordinates and monitors all aspects of the active treatment process. RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	
W000262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview for 1 of 4 sampled clients (#1), the facility's HRC (Human Rights Committee) failed to review and approve client #1's use of psychotropic medication for pre-sedation for dental procedures. Findings include: Client #1's record was reviewed on 11/6/14 at 1:00 PM. Client #1's dental summary progress report dated 3/13/14 indicated, "[Client #1] presents for recall with [staff #1] who reports that [client #1] has had 1 milligram Xanax preoperatively. [Client #1] is nicely sedated." Client #1's Electronic Health Record treatment history indicated the following: -11/9/09, "Valium 10 milligrams 30	W000262	**CORRECTION:** *The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.* Specifically, the facility has located documentation of approval from the Human Rights Committee for Client #1's use of psychotropic medication for pre-sedation for dental procedures. A review of Human Rights Committee documentation indicated that this deficient practice did not affect any additional clients. **PREVENTION:** The QIDP will be retrained regarding the need to assure that the Human Rights Committee engages in a dialog to reach decisions regarding restrictive programs for all clients. The QIDP, facility nurse and	12/12/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G447	A. BUILDING 00 B. WING	11/12/2014

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	minutes prior to next visit to continue and complete debridement." -1/11/10, "[Client #1] had not had the Valium 10 milligrams as prescribed. Will reschedule to fine scale with Valium 10 milligrams 30 minutes prior to treatment." -4/12/10, "[Client #1] has had the Valium 10 milligrams as prescribed." -11/24/10, "Prescription for 10 milligrams of Valium was prescribed." -3/19/12, "Prescription written out for Diazepam 10 milligram tablet." -4/9/12, "Treatment postponed because patient had not received Valium as ordered." Client #1's consent for medication form dated 12/7/13 did not indicate documentation of HRC review or approval of client #1's use of Valium 10 milligrams or Xanax 1 milligram for sedation prior to dental procedures. CS (Clinical Supervisor) #2 was interviewed on 11/6/14 at 2:15 PM. CS #2 indicated the facility's HRC should review and approve client #1's psychotropic medication usage.		Human Rights Committee liaison will each maintain copies of Human rights Committee approval forms to assure the ability to reproduce copies of HRC records for surveyors upon request. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to, due process and prior written informed consent. Administrative staff will conduct visits to the facility on a weekly basis for the next 30 days. **ADDENDUM, 12/21/14: After one month, The Operations Team and QIDP will observe active treatment sessions and review documentation no less than every two weeks. The Operations Team will maintain no less than a twice monthly presence in the home on an ongoing basis, to assure that the QIDP integrates, coordinates and monitors all aspects of the active treatment process.** The Program Manager will incorporate monitoring of annual HRC approvals of restrictive programs into the current tracking process. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G447	A. BUILDING 00 B. WING	11/12/2014

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	9-3-4(a)			
W000263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 2 of 4 sampled clients (#1 and #2), the facility's HRC (Human Rights Committee) failed to obtain the written informed consent of clients #1 and #2's guardians regarding the use of psychotropic medication for behavior management. Findings include: 1. Client #1's record was reviewed on 11/6/14 at 1:00 PM. Client #1's dental summary progress report dated 3/13/14 indicated, "[Client #1] presents for recall with [staff #1] who reports that [client #1] has had 1 milligram Xanax preoperatively. [Client #1] is nicely sedated." Client #1's Electronic Health Record treatment history indicated the following: -11/9/09, "Valium 10 milligrams 30 minutes prior to next visit to continue and complete debridement."	W000263	**CORRECTION:** *The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.* Specifically for Clients #1, #2, #3 and #4, through assessment, the interdisciplinary team has determined that only one individual (Client #2) needs to have limited access to soft drinks for documented health reasons. The modification of this right will be incorporated into Client #2's support plan based on physician recommendations and after the committee assures that written informed consent from client #2's guardian has been obtained. Through assessment, the team determined that this deficient practice affected 4 additional clients: #5, #6, #7 and #9. Access to soft drinks will not be limited for these individuals. **PREVENTION:** Professional staff will be retrained regarding the need to obtain prior written informed consent from guardians, advocates and healthcare	12/12/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G447	A. BUILDING 00 B. WING	11/12/2014

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	-1/11/10, "[Client #1] had not had the Valium 10 milligrams as prescribed. Will reschedule to fine scale with Valium 10 milligrams 30 minutes prior to treatment." -4/12/10, "[Client #1] has had the Valium 10 milligrams as prescribed." -11/24/10, "Prescription for 10 milligrams of Valium was prescribed." -3/19/12, "Prescription written out for Diazepam 10 milligram tablet." -4/9/12, "Treatment postponed because patient had not received Valium as ordered." Client #1's ISP (Individual Support Plan) dated 12/7/13 indicated client #1 had a legal guardian. Client #1's record did not indicate documentation of client #1's guardian's written informed consent for client #1's use of Valium 10 milligrams or Xanax 1 milligram for sedation prior to dental procedures. 2. Client #2's record was reviewed on 11/6/14 at 12:00 PM. Client #2's POF (Physician's Order Form) dated 9/19/14 indicated client #2 received Seroquel 100 milligrams tablet (anxiety) and		representatives for all restrictive programs prior to implementation. Retraining will focus on assuring that the QIDP has a clear understanding of what specifically constitutes a restrictive program and proper preparation for presenting program modifications guardians and other legal representatives. Prior to granting approval to restrictive programs, the Human Rights Committee will obtain confirmation that the facility has received prior written informed consent from guardians or other legal representatives. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to due process and prior written informed consent. Administrative staff will conduct visits to the facility on a weekly basis for the next 30 days. **ADDENDUM, 12/21/14: After one month, The Operations Team and QIDP will observe active treatment sessions and review documentation no less than every two weeks. The Operations Team will maintain no less than a twice monthly presence in the home on an ongoing basis, to assure that the QIDP integrates, coordinates and monitors all aspects of the active treatment process. RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	

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	Clonazepam 1 milligram tablet (anxiety) daily for behavior management. Client #2's ISP dated 11/14/13 indicated client #2 had a legal guardian. Client #2's record did not indicate documentation of client #2's guardian's written informed consent for the use of Seroquel or Clonazepam for the management of client #2's behavior. CS (Clinical Supervisor) #2 was interviewed on 11/6/14 at 2:15 PM. CS #2 indicated clients #1 and 2 should have their guardians' written informed consent for the use psychotropic medication for the management of their behavior. 9-3-4(a)			
W000264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility's specially constituted committee (Human Rights Committee) failed to review the facility's	W000264	**CORRECTION:** *The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug*	12/12/2014

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	practice of restricting clients #1, #2, #3 and #4 from soda. Findings include: Observations were conducted at the group home on 11/5/14 at 5:00 PM through 6:05 PM. At 5:30 PM, client #2 walked into the group home's kitchen area where staff #1 was standing. Client #2 stated, "Pop. Pop." Staff #1 replied, "Not tonight." Client #2 then returned to the living room area. At 5:45 PM, client #8 returned to the group home from an outing with her family. Client #8 had a fast food cup with soda. Client #2 approached client #8, stretched her hands out toward the cup and made a 'pop' sounding vocalization. Client #2 was redirected and client #8 left the area. At 6:04 PM, client #2 stood in the hallway between the kitchen area and the dining area pointing the top of the kitchen cabinet. On the top of the kitchen cabinet was a fast food cup of soda. Client #2 pointed toward the cup and made 'pop' sounding vocalizations. Staff #1 was interviewed on 11/5/14 at 5:35 PM. Staff #1 stated, "They only get pop on Friday. That's when we go out to eat." CS #2 (Clinical Supervisor) was		*usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.* Specifically for Clients #1, #2, #3 and #4, through assessment, the interdisciplinary team has determined that only one individual (Client #2) needs to have limited access to soft drinks for documented health reasons. The modification of this right will be incorporated into Client #2's support plan based on physician recommendations and after approval from the guardian and the Human Rights Committee has been obtained. Through assessment, the team determined that this deficient practice affected 4 additional clients: #5, #6, #7 and #9. Access to soft drinks will not be limited for these individuals. **PREVENTION:** The QIDP has been retrained regarding the need to assure restrictive measures are implemented only when an assessed need has been identified and informed consent has been obtained. The	

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	interviewed on 11/6/14 at 2:15 PM. CS #2 indicated clients #1, #2, #3 and #4 should have diet soda if they choose. 1. Client #1's record was reviewed on 11/6/14 at 1:00 PM. Client #1's record did not indicate documentation of HRC review of the facility's practice of restricting client #1 from soda. 2. Client #2's record was reviewed on 11/6/14 at 9:36 AM. Client #2's record did not indicate documentation of HRC review of the facility's practice of restricting client #1 from soda. 3. Client #3's record was reviewed on 11/6/14 at 12:00 PM. Client #3's record did not indicate documentation of HRC review of the facility's practice of restricting client #1 from soda. 4. Client #4's record was reviewed on 11/6/14 at 11:13 AM. Client #4's record did not indicate documentation of HRC review of the facility's practice of restricting client #1 from soda. Client #4 was interviewed on 11/10/14 at 12:45 PM. When asked if she was able to drink soda in her group home, client #4 stated, "We do sometimes. We had some this weekend. We don't get it too often."		Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring, including but not limited to assessing client's need for restrictive programs and their ability to give informed consent. Members of the Operations Team will review facility support documents no less than monthly to assure that accurate informed consent assessments are in place and that prior written informed consent is obtained for all restrictive programs. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	

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	9-3-4(a)			
W000312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 1 of 4 sampled clients on behavior controlling medications (#1), the facility failed to ensure client #1 had an active treatment program with a plan of reduction. Findings include: Client #1's record was reviewed on 11/6/14 at 1:00 PM. Client #1's dental summary progress report dated 3/13/14 indicated, "[Client #1] presents for recall with [staff #1] who reports that [client #1] has had 1 milligram Xanax preoperatively. [Client #1] is nicely sedated." Client #1's Electronic Health Record treatment history indicated the following: -11/9/09, "Valium 10 milligrams 30 minutes prior to next visit to continue and complete debridement." -1/11/10, "[Client #1] had not had the	W000312	**CORRECTION:** *Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.* Specifically the team will develop a desensitization plan to support Client #1 with developing the ability to tolerate dental procedures with a reduced level of sedation and the goal of eventual elimination of the need for pre-appointment sedation. A review of facility BSPs indicated this deficient practice did not affect additional clients. **PERVENTION:** The QIDP has been retrained regarding the need to incorporate goals to reduce and eventually	12/12/2014

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	Valium 10 milligrams as prescribed. Will reschedule to fine scale with Valium 10 milligrams 30 minutes prior to treatment." -4/12/10, "[Client #1] has had the Valium 10 milligrams as prescribed." -11/24/10, "Prescription for 10 milligrams of Valium was prescribed." -3/19/12, "Prescription written out for Diazepam 10 milligram tablet." -4/9/12, "Treatment postponed because patient had not received Valium as ordered." Client #1's BSP (Behavior Support Plan) dated 12/7/13 did not indicate client #1's use of Valium 10 milligrams or Xanax 1 milligram for pre-sedation for dental procedures. Client #1's BSP did not indicate documentation of an active treatment plan to reduce client #1's need for pre-sedation for dental procedures. CS (Clinical Supervisor) #2 was interviewed on 11/6/14 at 2:15 PM. CS #2 indicated the use of psychotropic medication to manage client behavior should be included in the client's BSP. 9-3-5(a)		eliminate the use of behavior controlling medications into support plans whenever such medications are prescribed. The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring, including but not limited to assessing developmental and behavioral needs. Additionally, members of the Operations Team will review facility Behavior Support Plans no less than monthly and to assure plans for the reduction and eventual elimination of behavior controlling medications are included. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	

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W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 3 of 4 sampled clients (#1, #2 and #4), the facility's nursing services failed to met the health needs of clients #1, #2 and #4. Findings include: 1. Client #1's record was reviewed on 11/6/14 at 1:00 PM. Client #1's PCP (Primary Care Physician) fax form dated 2/10/14 indicated, "[Client #1] went to gynecologist... labs were drawn CBC (Complete Blood Count) with differential. Labs found to be abnormal. Gynecologist suggested... fax results." Client #1's PCP fax dated 2/10/14 indicated client #1's PCP's response was "Make appointment with Hematologist for high platelets." Client #1's record did not indicate documentation of client #1 being seen/evaluated by a Hematologist regarding her high platelets as recommended on the 2/10/14 PCP correspondence. 2. Client #2's record was reviewed on 11/6/14 at 9:36 AM. Client #2's POF (Physician's Orders Form) dated 9/19/14	W000331	**CORRECTION:** *The facility must provide clients with nursing services in accordance with their needs.* Specifically: Overdue labs for Clients #1, #2 and #4 will be collected and the results forwarded to their doctor's as ordered. A review of medical documentation indicated that this deficient practice also affected clients #6 and #8. Therefore required labs for these additional clients will be collected and the results forwarded to their doctor's as well. **PREVENTION:** The Nurse Manager will assist the facility nurse and direct support medical coach with tracking routine appointments and lab tests to assure they occur as recommended. Additionally, Operations Team members including the Nurse Manager will review medical documentation while auditing active treatment sessions, no less than weekly for the next 30 days. **ADDENDUM, 12/21/14: After one month, The Operations Team and QIDP will observe active treatment sessions and review documentation no less than every two weeks. The Operations Team will maintain no less than a twice monthly presence in the home on an**	12/12/2014

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	indicated client #2's Depakote (seizures) levels should be checked every 2 months and HgbA1C (glucose) should be checked every 3 months. Client #2's Laboratory Report form(s) indicated the following: -10/16/13: Valproic Acid -3/27/14: CBC and CMP (Complete Metabolic Panel). -6/7/14: Glucose and Valproic Acid -10/22/14: included glucose with no documentation of Valproic Acid. Client #2's record did not indicate documentation of client #2's Depakote levels being checked every 2 months or glucose/HgbA1C levels being checked every three months. 3. Client #4's record was reviewed on 11/6/14 at 11:13 AM. Client #4's POF dated 9/19/14 indicated, "HgbA1C (glucose) every 3 months." Client #4's QNA (Quarterly Nursing Assessment) dated 1/1/13 through 12/31/13 indicated client #4 had HgbA1C testing completed on 5/20/13 and 11/4/13. Client #4's QNA dated 1/1/14 through 11/5/14 indicated client #4's HgbA1C testing had been completed on 2/20/14 and 6/16/14. Client #4's diabetes CHRHP (Comprehensive High Risk Health Plan) dated 10/17/14 indicated, "(9.) Nurse will assure that		**ongoing basis, to assure medical follow-up and lab testing occurrs as recommended.** **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Health Services Team, Operations Team	

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	HgbA1C is obtained quarterly." RN (Registered Nurse) #1 was interviewed on 11/6/14 at 2:30 PM. RN #1 indicated client #1's PCP had changed due to the PCP no longer accepting Medicaid patients. RN #1 indicated client #1 would be seen by a new PCP on 12/3/14 and would be assessed to determine if a referral for a hematologist was still needed. RN #1 indicated client #1 had not been seen by a hematologist. RN #1 indicated laboratory orders should be implemented as indicated on each clients Physician's Orders Form. 9-3-6(a)			
W000356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. Based on record review and interview for 1 of 4 sampled clients (#2), the facility failed to ensure client #2 received dental treatment services. Findings include: Client #2's record was reviewed on 11/6/14 at 9:36 AM. Client #2's record did not indicate documentation of dental	W000356	**CORRECTION:** *The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.* Specifically, the facility will assist Client #2 with receiving recommended dental follow-up.	12/12/2014

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	examination or maintenance services being provided to ensure client #2's dental health. RN (Registered Nurse) #1 was interviewed on 11/6/14 at 2:30 PM. RN #1 indicated client #2 should receive dental examinations and maintenance services to ensure her dental health. 9-3-6(a)		An audit conducted by the administrative team determined that this deficient practice also affected Client #8. Therefore the facility will also assist Client #8 with receiving recommended dental follow-up. **PREVENTION:** The Nurse Manager will assist the facility nurse and direct support medical coach with tracking routine dental appointments and follow-ups to assure they occur as recommended. Additionally, Operations Team members including the Nurse Manager will review medical documentation while auditing active treatment sessions, twice monthly for the next 90 days to dental appointments occur as recommended. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Health Services Team, Operations Team	

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W000474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. Based on observation, record review and interview for 1 of 4 sampled clients (#2), the facility failed to implement client #2's dietary orders. Findings include: RM (Resident Manager) #1 was interviewed on 11/5/14 at 5:53 PM. When asked which clients had specialized diet orders, i.e. mechanical soft, pureed, thick liquids, RM #1 stated, "[Client #6] is mechanical soft. Everyone else is regular. [Client #6] is the only one." Observations were conducted at the group home on 11/5/14 from 5:00 PM through 6:15 PM. At 6:04 PM, client #2 participated in the group home's family style evening meal. Client #2 ate pizza and salad. Client #2's food was not chopped or mechanical soft. Client #2's record was reviewed on 11/6/14 at 9:36 AM. Client #2's Record of Visit (ROV) form dated 6/21/12 indicated client #2 should have mechanical soft diet to prevent choking. Client #2's Comprehensive High Risk Health Plan (CHRHP) dated 7/7/14	W000474	**CORRECTION:** *Food must be served in a form consistent with the developmental level of the client.* Specifically, all facility staff will be formally retrained regarding preparation of modified texture diets, including but not limited to Client #2's modified texture diet. A review of dietary recommendations indicated this deficient practice affected one additional individual –Client # 5. Staff will also be trained toward proper implementation of this prescribed diet. **PREVENTION:** The Residential Manager will be expected to observe no less than one morning and one evening active treatment session per week and the Team Leader will be required to observe and participate in active treatment sessions on varied shifts no less than five times per week. The QIDP will also maintain an ongoing presence at the facility. During Active Treatment observations, supervisors will assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff implement diets and dining plans as ordered. Additionally, members of the Operations Team and the QIDP will conduct active treatment observations on a weekly basis	12/12/2014

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	indicated, "Follow mechanical soft with thin liquids 5 milliliter control flow cup guidelines at all times." CS (Clinical Supervisor) #2 was interviewed on 11/6/14 at 2:15 PM. CS #2 indicated client #2's dietary orders should be implemented by staff. 9-3-8(a)		for the next 30 days, to assure staff implement diets and dining plans as ordered. **ADDENDUM, 12/21/14: After one month, The Operations Team and QIDP will observe active treatment sessions and review documentation no less than every two weeks. The Operations Team will maintain no less than a twice monthly presence in the home on an ongoing basis, to assure that the QIDP integrates, coordinates and monitors all aspects of the active treatment process. RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	
W009999	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met. 460 IAC 9-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division (15) A fall resulting in injury, regardless of the severity of the injury.	W009999	**CORRECTION:** *The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division (15) A fall resulting in injury, regardless of the severity of the injury.* Specifically, the Residential Manager will be retrained regarding requirements for reporting incidents to the Indiana Bureau of Developmental Disability Services, Bureau of Quality Improvement Services	12/12/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G447	A. BUILDING 00 B. WING	11/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	This state rule was not met as evidenced by: Based on record review and interview for 1 of 2 falls with injury reviewed, the facility failed to report client #6's fall with injury to the BDDS (Bureau of Developmental Disabilities Services) within 24 hours in accordance with state law. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports, IRs (Incident Reports) and investigations were reviewed on 11/5/14 at 2:18 PM. The review indicated the following: -IR dated 8/24/14 indicated, "[Client #6] yelled for staff to help (sic) Upon arrival staff (sic) discovered [client #6] on her stomach on in her room. [Client #6] told staff she was trying to get in her wheelchair. [Client #6] has a rug burn above her right eye." -The review did not indicate documentation of client #6's 8/24/14 fall with injury was reported to the BDDS. CS (Clinical Supervisor) #1 was		and Adult Protective Services. **PREVENTION:** Supervisory staff will review all facility documentation to assure incidents are reported as required. The governing body has added an additional layer of supervision at the facility which will enhance oversight of the incident reporting process. Additionally, internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility Residential Manager or on-call supervisor as appropriate, to assure incidents are reported to state agencies as required. If, through investigation, administrators discover that a Residential Manager has failed to report incidents to state agencies as required the governing body will administer written corrective action up to and including termination of employment. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	

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	interviewed on 11/5/14 at 2:15 PM. CS #1 indicated falls with injury should be reported to the BDDS within 24 hours of knowledge of the incident. 9-3-1(b)			